



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TX 77504-2117

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-05-A880-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Medical Center Hospital charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum of 70% of billed charges. This is supported by a managed care contract with 'Focus'."

Amount in Dispute: \$16,034.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The entire admission was denied x206, not related to the compensable injury. [Injured employee] sustained an injury on 9/26/03 at Emerald Foods. An empty CO2 tank fell on her foot. The procedure she had on 8/23/04 was an outpatient left lumbar sympathetic block. The back is not a compensable injury. We have documentation from our [sic] RME doctor on 4/27/04 and a CCH upheld on 7/15/04, that the back is not a compensable injury. RSD and CRPS have also been denied."

Response Submitted by: Liberty Mutual Insurance, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 23, 2004	Outpatient Surgery	\$16,034.15	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on July 27, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 14, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - R, X206 – The service(s) is for a condition (s) which is not related to the covered work related injury. For reconsideration of charges, please submit documentation to support the relatedness of services rendered to the work related injury.
 - F, 652 – Recommendation of payment has been based on a procedure code which best describes services rendered.

Findings

1. The insurance carrier denied the services billed with reason code R, X206 - "The service(s) is for a condition(s) which is not related to the covered work related injury." The findings of the Contested Case Hearing of July 31, 2004 was against the claimant. Therefore, the Division does not have the authority to review services provided to an injured employee for non-compensable body areas.

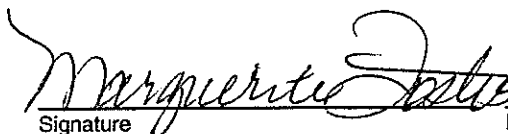
Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

 Marguerite Foster
Signature Medical Fee Dispute Resolution Officer

November 22, 2011
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

